U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 26 July 2005

In the Matter of:

EVERETT J. STAMPER,
Claimant,

v. **Case No.: 2003-BLA-06457**

WESTERMAN COAL COMPANY, INC./
KENTUCKY COAL PRODUCERS,
Employer/Carrier, and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

Monica Rice Smith, Esq., Edmond Collett, PSC, Hyden, KY
For Claimant

David H. Neeley, Esq., Neeley & Reynolds Law Offices, PSC, Prestonburg, KY
For Employer

Before: PAMELA LAKES WOOD
Administrative Law Judge

DECISION AND ORDER GRANTING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §901, *et. seq.* (hereafter "the Act") filed by Claimant Everett J. Stamper ("Claimant") on August 13, 2001. Claimant has indicated that a claim was previously filed and later withdrawn.[1] The putative responsible operator is Westerman Coal Company ("Employer") which is insured

[1] The prior claim was not included in the record; however, the District Director's Summary of Medical and Employment Evidence in the Proposed Decision and Order of May 6, 2003 indicated that "this is a refiled claim rather than a modification request because more than one (1) year elapsed between the prior denial and the filing of the claim." (DX 29). A review of the Case Tracking System for the Office of Administrative Law Judges reveals three prior claims: Case Nos. 1995-BLA-01025 (Judge Mosser, 8/25/1995 remand or dismissal); 1997-BLA-01116 (Judge Roketenetz, benefits denied 5/28/1999); and 2001-BLA-00370 (Judge Hillyard, withdrawn). In addition, the Summary of Evidence stated that "the Administrative Law Judge Decision and Order dated 5/28/99 was adopted establishing eleven years of coal mine employment." *Id.* However, inexplicably, in the Proposed Decision and Order itself, the district director found only 6 years of coal mine employment. *Id.* The prior files were not enclosed in the record; inclusion of a prior file is not required when the claim is withdrawn.

through the Kentucky Coal Producers ("Carrier"). Claimant is currently receiving interim benefits from the Black Lung Disability Trust Fund.

Part 718 of title 20 of the Code of Federal Regulations is applicable to this claim,[2] as it was filed after March 31, 1980, and the regulations amended as of December 20, 2000 are also applicable, as this claim was filed after January 19, 2001. 20 C.F.R. §718.2. In *National Mining Assn. v. Dept. of Labor,* 292 F.3d 849 (D.C. Cir. 2002), the U.S. Court of Appeals for the D.C. Circuit rejected the challenge to, and upheld, the amended regulations with the exception of several sections.[3] The Department of Labor amended the regulations on December 15, 2003, solely for the purpose of complying with the Court's ruling. 68 Fed. Reg. 69929 (Dec. 15, 2003).

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, including all evidence admitted and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

STATEMENT OF THE CASE

The instant claim was filed on August 13, 2001. (DX 2).[4] Claimant was examined for the Department of Labor examination by Valentino Simpao, M.D. on October 16, 2001. (DX 10). On July 30, 2002, the District Director issued a Schedule for the Submission of Additional Evidence, which stated that Claimant would not be entitled to benefits if a decision were issued at that time and that the named coal mine operator ("Westerman Coal Co., Inc") was the responsible operator. (DX 23). A Proposed Decision and Order, Award of Benefits (issued by the District Director on May 6, 2003) determined that the Claimant was entitled to benefits because the evidence showed that the claim was timely filed, that Claimant had pneumoconiosis, and that Claimant was totally disabled by the disease. (DX 29). The District Director also found that Claimant worked as a coal miner for six years. *Id.* The responsible operator was again identified as "Westerman Coal Co., Inc." *Id.* Employer, through counsel, requested a hearing and the case was transferred to the Office of Administrative Law Judges for a hearing on May 28, 2003. (DX 30, DX 31).

A hearing in the above-captioned matter was held on April 29, 2004 in London, Kentucky. All parties, with the exception of the Director submitted Designation of Evidence/BLBA Evidence Summary Forms. The Claimant was the only witness to testify. At the hearing, Director's Exhibits 1 through 36 ("DX 1" through "DX 36"), Claimant's Exhibit 1 through 3 ("CX 1" through "CX 3"), and Employer's Exhibit 1 and 2 ("EX 1" and "EX 2") were admitted into evidence. (Tr. 5-6; 27-30). The record was closed at the end of the hearing, and the parties were allowed 90 days to submit optional briefs or written closing arguments, which period could be extended by stipulation. (Tr. 30-31).

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[2] Section and part references appearing herein are to Title 20 of the Code of Federal Regulations unless otherwise indicated.

[3] Several sections were found to be impermissibly retroactive and one which attempted to effect an unauthorized cost shifting was not upheld by the court.

[4] Director's Exhibits 1 through 36, admitted into evidence at the April 29, 2004 hearing, will be referenced as "DX" followed by the exhibit number and the hearing transcript will be referenced as "Tr." followed by the page number.

Thereafter, Employer's Brief was timely filed on July 20, 2004, and Claimant's Brief was filed on August 3, 2004, and is also accepted as timely.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Issues/Stipulations

The issues before me are length of coal mine employment;[5] the existence of pneumoconiosis; its causal relationship to coal mine employment; total disability; and causation of total disability. (Tr. 6). Additional issues (concerning the new regulations and the procedures applied thereunder) were listed for appellate purposes. *Id*.

Medical Evidence

X-ray Evidence

Interpretations of chest X-rays taken between October 1994 and October 2001 that utilize the ILO system and are in compliance with the regulatory standards, are summarized below.[6]

Exhibit No./ Party designating	Date of X-ray/ Reading	Physician/ Qualifications[7]	Interpretation
DX 17 (Employer's Initial)	10/19/94/ 10/02/01	D. Halbert BCR, B-Reader	Completely Negative, Quality 2.
DX 25 (Claimant's Initial)	10/29/97 same	G. Baker B-Reader	Pneumoconiosis 1/0, p/s, upper left and lower four zones, Quality 1.
DX 25 (Claimant's Initial)	10/18/00 same	G. Baker B- Reader	Pneumoconiosis 1/0, p/q, upper left and lower four zones, Quality 1.
DX 10 DOL Exam	10/16/01 same	V. Simpao A-Reader[8]	Pneumoconiosis 1/0, p/p, all zones; Quality 1.
DX 18 DOL Exam	10/16/01/ 11/24/01	E.N. Sargent BCR, B-Reader	Quality Only – Quality 1.
DX 11 (Employer's Initial)	10/25/01 same	R.T. Westerfield B-Reader	Completely Negative, Quality 1.

[5] Both parties initially stipulated to eleven years of coal mine employment. (Tr. 7). However, counsel for the Employer later stated that the stipulation was in error and he intended to stipulate to six years of coal mine employment, as the Employer indicated before the district director. *Id.* at 10. The Director's Exhibits reflect that the Employer only agreed to six years as that was the amount listed in the proposed Decision and Order (DX 29, 30). Thus, the issue remains a contested issue and the list of issues is amended to so reflect. **SO ORDERED**.

[6] In addition to the x-ray readings listed in the table, x-ray interpretations that do not utilize the ILO system appear in the Claimant's medical records. (DX 25).

[7] BCR refers to a board certified radiologist. B-reader refers to a physician certified by NIOSH.

[8] Dr. Simpao's qualifications were found at www.oalj.dol.gov (NIOSH Certified B-Reader List).

Exhibit No./ Party designating	Date of X-ray/ Reading	Physician/ Qualifications[7]	Interpretation
CX 1 (Claimant's Rebuttal)	10/25/01/ 3/12/04	M. Alexander BCR, B-Reader	Pneumoconiosis 1/1, p/q, all zones, circumscribed pleural thickening (plaque, width A), Quality 1.

Pulmonary Function Tests

Pulmonary function tests taken on October 16, 2001 and February 5, 2001 (DOL examination); October 29, 1997 and October 18, 2000 (DX 25) (Baker examinations, Claimant's Initial); October 25, 2001 (Westerfield examination, Employer's Initial) (DX 11); and July 6, 2000 (Ducu treatment records, Claimant's Initial) (DX 25), produced the following results[9]:

Exhibit No.	Date/ Physician	Age/ Height	FEV1	FVC	MVV	FEV1/FVC
DX 25	10/29/97 G. Baker	52 72 inches	2.00 (pre)	3.24 (pre)	Not done	62 % (pre)
DX 25	7/06/00[10] M. Ducu	54 73 inches	2.67 (pre) 2.66 (post)	4.51 (pre) 4.61 (post)	Not done	59 % (pre) 58 % (post)
DX 25	10/18/00 G. Baker	55 72 inches	2.11 (pre)	3.62 (pre)	65 (pre)	58 % (pre)
DX 10	10/16/01 * V. Simpao	56 72 inches	1.80 (pre)	2.72 (pre)	42 (pre)	66 % (pre)
DX 11	10/25/01 B. Westerfield	56 71 inches	2.02 (pre) 2.30 (post)	2.84 (pre) 3.25 (post)	33 (pre) 29 (post)	71 % (pre) 71 % (post)
DX 13	02/05/02 * V. Simpao	56 72 inches	2.13 (pre)	3.35 (pre)	51 (pre)	64 % (pre)

Under subparagraph (i) of section 718.204(b)(2), total disability is established if the FEV1 value is equal to or less than the values set forth in the pertinent tables in 20 C.F.R. Part 718, Appendix B, for the miner's age, sex and height, if in addition, the tests reveal qualifying FVC or MVV values under the tables, or an FEV1/FVC ratio of less than 55%. The four most recent (pre-bronchodilator) tests yielded qualifying values, but the post-bronchodilator test taken on October 25, 2001 was nonqualifying based upon the FEV1 value and the earlier two tests were nonqualifying.

[9] The two pulmonary function tests conducted by Dr. Simpao on 10/16/01 and 2/5/02 (asterisked) were invalidated by Dr. Burki based upon Claimant's less than optimal effort. (DX 12; DX 15). However, Dr. Broudy stated at his deposition that the results were not clearly invalid based upon his review of the tracings and raw data. (EX 1 at 17). Neither party designated those test results and no designation of evidence form was filed by the Director.

[10] Both the pulmonary function test and arterial blood gases by Dr. Ducu are mistakenly dated 7/18/00 in the Proposed Decision by the District Director. *See* (DX 29).

Arterial Blood Gases

Arterial blood gases were taken on October 16, 2001 and February 5, 2002 (DOL examination) (DX 10, 14);[11] on October 29, 1997 and October 18, 2000 (Baker's prior examinations, Claimant's Initial) (DX 25); on October 25, 2001 (Westerfield examination, Employer's Initial); and on July 18, 2000 (Ducu treatment records, Claimant's Initial) (DX 25). No exercise testing was performed during any of the tests; according to Dr. Simpao, the exercise portion of the test was contraindicated due to chest pain on exertion. The ABGs produced the following values, which were not qualifying under Part 718, Appendix C: [12]

Exhibit No.	Date	Physician	pCO2	pO2	Qualifying?
DX 25	10/29/97	G. Baker	48.4 (rest)	78.1 (rest)	No
DX 25	7/06/00	M. Ducu	40.3 (rest)	85.1 (rest)	No
DX 25	10/18/00	G. Baker	45 (rest)	72 (rest)	No
DX 10	10/16/01	V. Simpao	50.0 (rest)	80.4 (rest)	Invalidated [Borderline qualifying][13]
DX 11	10/25/01	B. Westerfield	46 (rest)	67 (rest)	No
DX 14	2/05/02	V. Simpao	47.7	84.6	No

Medical Opinions

Medical opinions were rendered by four physicians, not including a medical opinion by Dr. Mirella Ducu appearing in Claimant's treatment records.[14] Specifically, opinions were issued by Dr. Glen Baker in connection with his October 29, 1997, and October 18, 2000 examinations of the Claimant (DX 25) (Claimant's Initial);[15] Dr. Valentino Simpao in connection with the October 16, 2001 DOL examination of Claimant (DX 10) (DOL Exam); Dr. Byron Westerfield in a report dated September 16, 2002 and at his January 24, 2002 deposition, based upon his October 25, 2001 examination of the Claimant (DX 16; DX 28) (Employer's Initial); and Dr. Bruce Broudy's medical report in connection with his review of the medical

[11] The February 5, 2002 test stated that exercise studies were not performed due to chest pain on exertion.

[12] The blood gas studies performed by Dr. Simpao on 10/16/01 were found to be technically unacceptable by Dr. Burki because the PCO2 was not compatible with the PO2. (DX 12). However, the 2/5/02 ABG was not invalidated. (DX 15).

[13] The chart in Appendix C requires an arterial PO2 of less than or equal to 60 for an arterial PCO2 of 40-49 in order to qualify, and it also provides that any PO2 value is qualifying for an arterial PCO2 of "Above 50." However, the table does not indicate what if any value would be qualifying for a PO2 of 50. 20 C.F.R. Part 718, Appendix C.

[14] The District Director considered Dr. Ducu's letter report dated July 18, 2000 and associated treatment records as a medical opinion report. That report does not qualify as such under the quality standards in the new regulations because, although clinical test results were attached, it did not include the miner's medical and employment history. *See* 20 C.F.R. §718.104. However, the quality standards are only applicable to medical evidence developed after January 19, 2001. 20 C.F.R. §718.101(b). In any event, Dr. Ducu's letter will be considered along with the Claimant's medical records and, where pertinent, as a medical opinion.

[15] In addition, a medical report dated October 5, 2000 by Dr. Baker was also considered by the District Director. It was listed as a treatment record in Claimant's designation of evidence form.

records on August 22, 2003 and his deposition testimony of September 5, 2003 (EX 1; EX 2) (Employer's Initial).[16] These reports and deposition transcripts are summarized below.

Glen Baker, M.D. Dr. Baker, a board-certified pulmonary medicine specialist, examined the Claimant on October 29, 1997 and on October 18, 2000 on behalf of Claimant. He prepared contemporaneous examination reports based upon each of those examinations. (DX 25).

In his November 3, 1997 examination form report, relating to the October 29, 1997 examination, Dr. Baker recorded a detailed history (including employment history, family history, medical history, and social history); a list of complaints and symptoms and their duration; and detailed physical findings. He summarized the diagnostic testing as follows:

1. Chest x-ray was positive for pneumoconiosis, category 1/0
2. Pulmonary function test showed moderate obstructive ventilatory defect
3. Arterial blood gases revealed mild resting arterial hypoxemia

In addition, Dr. Baker listed the following cardiopulmonary diagnoses (and respective bases for the diagnoses):

1. Coal Workers' Pneumoconiosis 1/0: abnormal chest x-ray and significant duration of exposure.
2. Mild resting arterial hypoxemia: ABG analysis
3. Chronic obstructive airway disease with moderate obstructive ventilatory defect: pulmonary function testing
4. Bronchitis: based on history

Dr. Baker listed the pulmonary impairment as Class III based on FEV1 between 41 and 59% of predicted values, and he further stated that Claimant's second impairment is based on the presence of pneumoconiosis requiring him to be removed from the environment causing the condition. He found that the patient's disease was the result of coal dust exposure. He based this finding on the abnormal x-ray, significant exposure to coal dust, and the absence of another condition to account for the abnormal x-ray findings. Additionally, he stated that coal dust exposure was also responsible for the obstructive airway disease, bronchitis, and resting arterial hypoxemia. (DX 25).

Dr. Baker provided another medical report dated October 18, 2000 based upon an examination conducted on that date at Claimant's request. In this report, he also summarized the Claimant's occupational, family, medical, and social history. The physical examination revealed diminished breath sounds and bilateral expiratory wheezes in the lungs. The heart rhythm was regular with no murmurs, clicks, rubs or gallop sounds. He again found a Class III impairment, which requires patient's removal from the exposure to the dust causing condition. The diagnostic impression was as follows:

[16] Although the District Director considered two reports by Dr. Westerfield dated October 25, 2001 and September 16, 2002 as Employer's initial evidence, the Employer designated Dr. Westerfield's September 16, 2002 report and Dr. Broudy's August 23, 2003 report as its initial medical opinion evidence.

1. Coal Workers' Pneumoconiosis, category 1/0 based on history of 11 years of coal dust exposure.
2. Mild resting hypoxemia based on arterial blood gas analysis.
3. Chronic Obstructive Airway Disease with moderate obstructive ventilatory defect and a mild degree of obstruction based on the pulmonary function testing.
4. Chronic bronchitis based on history.

Dr. Baker concluded that the diagnosed conditions were "due at least in part if not significantly so to his coal dust exposure." He stated that Claimant's smoking history is only for 10 to 12 years, and a 15 year smoking history is necessary in order to implicate smoking as a causal factor. In addition, he stated that Claimant quit smoking fifteen years ago and the current symptoms have been present only for the last ten to twelve years. (DX 25).

Valentino S. Simpao, M.D. Dr. Simpao, who is board-certified in internal medicine with a subspecialty in pulmonary disease, examined the Claimant on October 16, 2001 for the DOL exam. Dr. Simpao recorded a detailed history (including employment history, family history, and medical history); a list of present illnesses and symptoms and their duration; and detailed physical findings. He summarized the diagnostic testing as follows:

1. Chest x-ray positive for pneumoconiosis, category 1/1
2. Ventilatory study indicates moderate degree of restrictive and severe degree of obstructive airway disease
3. Arterial blood gases were normal
4. EKG was suspicious for ventricular enlargement.

The diagnosis was CWP 1/1 based upon multiple years of coal dust exposure. He stated that Claimant had moderate pulmonary impairment. In a supplemental form, he further stated that Claimant's condition was caused by coal mine employment based upon the findings on the chest x-ray and pulmonary function test along with the physical findings and symptomatology. In addition, the supplemental form stated that Claimant lacks the respiratory capacity to perform coal mining work or comparable employment based on the chest x-ray findings, pulmonary function test and physical findings. (DX 10).

Byron T. Westerfield, M.D. Dr. Westerfield, who is board certified in internal and pulmonary medicine, examined Claimant on October 25, 2001 and prepared reports dated October 25, 2001 and September 16, 2002 on behalf of Employer, the latter of which was designated by the Employer as one of its initial medical opinions. (DX 11, 16, 28).

In his September 16, 2002 report, which supplemented his earlier examination report and is in the nature of rebuttal, he reviewed the medical evaluations of Dr. Baker and other evidence. He summarized the x-ray evidence, pulmonary function tests, and arterial blood gases in Claimant's records. He stated that all spirometry studies (NOT including the ones performed in connection with the DOL examination and invalidated by Dr. Burki) were valid in his opinion. (DX 28).

On the PFT/ABG report form relating to the October 25, 2001 examination, he interpreted the spirometry as showing "mild obstructive and moderate restrictive ventilatory dysfunction" and significant improvement following inhaled bronchodilator. He also stated that the ABGs showed mild oxygen desaturation with minimal CO2 retention (DX 11).

Dr. Westerfield's opinion was that Claimant does not have CWP based upon the negative x-rays and limited exposure to coal dust. In addition, he stated that Claimant was not working in the coal mines during the years in which he developed the respiratory symptoms. Based upon the history of cigarette smoking and respiratory symptoms, he diagnosed Claimant with asthma. He also stated that CWP is a fibrotic disease which in its simple form does not progress and would not be causing the increased symptoms shown in Claimant's reports, as contrasted with COPD, which often progresses as the individual ages.[17] (DX 28).

***Westerfield Deposition*:** Dr. Westerfield testified on January 24, 2002 that he was currently the medical director of Commonwealth Respiratory Consultants in Lexington, Kentucky. (DX 16 at 3). He stated his educational and employment background, including pulmonary care, ambulatory care, and occupational lung disease practice. *Id.* at 4. He also stated that he is a B-Reader and is board certified in internal and pulmonary medicine. *Id.*

Dr. Westerfield testified that he examined Claimant on October 25, 2001.[18] (DX 16 at 5) He stated that the examination consisted of past respiratory history; occupational history; physical examination with emphasis on chest findings; PA chest x-ray; spirometry; arterial blood gas; and electrocardiogram. *Id.* at 5. He stated that the Claimant reported 14 to 15 years of underground coal mining employment. *Id.* at 7. Claimant also reported hospitalization for acute bronchitis, a significant history with heart conditions, and a smoking history of 18 years. *Id.*

Based upon the Claimant's shortness of breath, peripheral edema in both pretibial areas and ankles along with fluid retention, Dr. Westerfield believed that Claimant might suffer from heart failure. (DX 16 at 7-8). He stated that such fluid retention could also be present with kidney and liver problems; however, it is certainly seen with early heart failure in people who have a history of cardiovascular disease, untreated hypertension, or coronary artery disease. *Id.* at 8-9. He testified that Claimant reported a history of heart problems and having some form of heart failure. *Id.* at 9. Additionally, Claimant had told him that he was on social security disability for his heart conditions. *Id.*

On physical examination, Dr. Westerfield found the Claimant to be obese, weighing 265 pounds with a height of 71 inches. (DX 16 at 10. He also stated that Claimant's lungs were clear with no wheezing, rales or rhonchi. *Id.* at 11. Claimant had a PA chest x-ray, film quality 1, taken by a registered x-ray technician, which Dr. Westerfield, a B-reader, interpreted as negative. *Id.* at 11-12. Dr. Westerfield found no indication of pneumoconiosis or any other lung disease on the chest x-ray, after comparing it with the ILO standard classification. *Id.* at 12. He also stated that the chest x-ray showed no evidence of congestive heart failure [contrary to his

[17] On this point, Dr. Westerfield's opinion is directly contrary to the regulations, which state that pneumoconiosis is a latent and progressive disease which may first become detectable after cessation of coal mine employment. 20 C.F.R. § 718.201(c).

[18] The October 25, 2001 examination report was attached as an exhibit to Dr. Westerfield's deposition. (DX 16).

earlier hypothesis] or right-sided congestive heart failure with cor pulmonale. *Id.* He testified that he found the pulmonary function tests to be valid. *Id.* at 13. In addition, he stated that the pulmonary function test was done in adherence to the ATS criteria, and the results showed both restrictive and obstructive ventilatory dysfunction. *Id.* at 13-14. He stated that Claimant did respond to bronchodilators with a fourteen percent improvement, which suggested reversible airway obstruction. *Id.* at 14. By definition, reversible airway obstruction is asthma. *Id.*

At the time of his examination, Dr. Westerfield stated that the FVC was 2.84 (60 percent of predicted), FEV1 was 2.02 (53% of predicted), FEV1/FVC ratio was seventy-one percent, and MVV was invalid, because Claimant was too short of breath to perform it. (DX 16 at 14-16). Once the bronchodilator was administered, the FVC improved to 3.25 (68 percent of predicted), FEV1 improved to 2.3 (60% of predicted), and the FEV1/FVC ratio remained the same. *Id.* He explained that the improvement suggested reversible airway obstruction while the reduced FVC coupled with the only slightly reduced FEV1/FVC ratio suggested an element of restrictive lung disease as well. *Id.* at 14-15, 16.

Based upon the above, Dr. Westerfield determined that Claimant has an element of asthma with chronic bronchitis, which improves with bronchodilator. (DX 16 at 16). He stated that the asthma causes the production of mucus. *Id.* at 17. He also stated that Claimant told him of a recent hospital visit for bronchitis and noted that it could take a person with lung disease a long time to get over an acute infection. *Id.*

Dr. Westerfield testified that there was no evidence to attribute those findings to Claimant's history of exposure to coal dust. *Id.* Specifically, he found no evidence on the chest x-ray to support that coal dust caused the conditions. *Id.* He also mentioned the remoteness of his last exposure to coal dust in 1989, but he also acknowledged the remoteness of Claimant's smoking history *Id.* Dr. Westerfield further stated that CWP does not cause chronic bronchitis or asthma, and that individuals with simple CWP will have normal pulmonary function unless they are cigarette smokers. (DX 16 at 18). However, he stated that advanced cases of CWP (which he defined as category 3 or category 2) or progressive massive fibrosis are associated with respiratory impairment. *Id.*

According to Dr. Westerfield, the blood gas studies taken during his examination of the Claimant were abnormal, and the studies indicated that Claimant does not have normal gas exchange. (DX 16 at 18-19). Specifically, he opined that there is something impairing Claimant's ability to exchange oxygen for carbon dioxide. *Id.* at 19. Based upon the objective and clinical evidence, he thought that underlying asthma and chronic bronchitis, obesity, and heart dysfunction are the factors causing the impairment to oxygen exchange. *Id.* at 19, 20. He further stated that chronic bronchitis and asthma were conditions of the general public and were not attributed to Claimant's employment because there is no relationship between coal mining and asthma. *Id.* at 19-20.

In summary, Dr. Westerfield testified that his final diagnosis was that Claimant had both heart and lung disease with elements of chronic obstructive pulmonary disease. (DX 16 at 20). He stated that obesity contributes to these pulmonary dysfunctions. *Id.* He concluded his direct

testimony by stating that all of his opinions were based upon a reasonable medical certainty standard. *Id.* at 24.

Dr. Westerfield also stated that he interpreted the chest x-ray dated October 19, 1994 (read on October 26, 2001). *Id.* at 20-21. He based his opinion in part upon review of that x-ray. *Id.* at 23. His interpretation of that x-ray will not be discussed, as it exceeds the evidentiary limitations, discussed infra.

On cross-examination, he testified that he had based his opinions on a single examination of the Claimant, conducted on October 25, 2001, and that Claimant's chief complaint at that time was shortness of breath. (DX 16 at 24). He stated that Claimant told him that he quit smoking twenty years ago, and that the carboxyhemoglobin level verified that he was not smoking at the time of the examination. *Id.* at 24-25. Claimant told him that he had fourteen to fifteen years of coal dust exposure and explained that he would shoot coal or he would air out the areas where they shot coal. *Id.* at 24-25. Dr. Westerfield acknowledged that Claimant had a sufficient history of coal dust exposure such that a susceptible individual could be expected to contract CWP. *Id.* at 26. He testified that CWP is classically a restrictive abnormality, and Claimant has evidence of a restrictive ventilatory defect. *Id.* In addition, he stated that Claimant has Class II (25 percent) impairment under the AMA guidelines. *Id.*

Bruce Broudy, M.D. Dr. Broudy, who is board certified in internal medicine with a subspecialty in pulmonary diseases, reviewed Claimant's medical records and offered an opinion dated August 22, 2003. (EX 2). The report summarized the medical reports of Drs. Westerfield, Baker, Ducu, and Simpao, including the x-ray, spirometry, and arterial blood gas findings of each report. In addition, he cited Dr. Halbert's October 2, 2001 negative x-ray reading of the October 19, 1994 x-ray. Dr. Broudy disagreed with Dr. Ducu's finding that Claimant was 100% disabled despite the fact that the lung function readings exceeded the minimum federal criteria for disability for coal workers. In this regard, he stated that Dr. Ducu's pulmonary function study results were the best and supported the conclusion that Claimant retained the respiratory capacity to perform last coal mining employment. Moreover, he found that severe obstructive airway disease such as that of the Claimant is almost always caused by cigarette smoking. He stated that when CWP causes such impairment, it is usually restrictive and associated with advanced pneumoconiosis exhibited in x-ray findings, and Claimant's x-ray readings were category 1, which is not associated with disabling respiratory impairment. (EX 2).

Dr. Broudy also noted that Claimant was on medication for blood pressure, hypercholesterolemia, cardiac disease, and obstructive airways disease. He stated that the records also noted obesity. Based upon his review of the medical evidence, he stated that, although Claimant had sufficient exposure to coal mine dust to cause pneumoconiosis, the evidence did not support such finding. He stated that well qualified B-Readers read recent x-rays as negative; there was no evidence of pulmonary impairment or disability from the inhalation of coal mine dust; the impairment shown on spirometry was caused by obesity and other diseases; and the cardiac disease could be playing a role in the symptoms and lung function results. He concluded that there was no evidence that Claimant has significant pulmonary disease or respiratory impairment which arose from his occupation as a coal worker. (EX 2).

In addition to the above, he referenced a physical examination he conducted with Claimant on July 6, 1994. However, the information will not be discussed or considered based upon my finding, which is stated below, that such evidence is excluded under the evidentiary limitations. (EX 2).

***Broudy Deposition*:** Dr. Broudy also offered deposition testimony on September 5, 2003. He stated that he was a medical doctor specializing in internal medicine with a subspecialty in pulmonary medicine. (EX 1 at 3). In addition, he stated that he was a qualified B-Reader. *Id.* at 4-5.

Dr. Broudy explained that he compares the clinical films with classifications by the American College of Radiology- International Classification system. (EX 1 at 5). He stated that he began examining coal workers for occupational lung disease in 1977. *Id.* He stated that the equipment at the Lexington Clinic complies with the U.S. Department of Labor standards. *Id.* Additionally, he stated that the guidelines for disability with regard to the administration of spirometric and blood gas testing are followed. *Id.* at 6. He also confirmed that the testing was performed by qualified technicians. *Id.*

He stated that he reviewed the medical evidence provided by Employer's counsel in order to determine if Claimant had pneumoconiosis or any pulmonary dysfunction caused by coal dust inhalation. (EX 1 at 7). Also, he reviewed the records of Drs. Baker, Ducu, Westerfield, and Simpao along with an x-ray re-read by Dr. Halbert, and he summarized the findings in the report. *Id.* at 7-8. Dr. Broudy opined that Claimant did not have coal workers' pneumoconiosis based upon the x-ray readings of two well-qualified B-Readers, and he concluded that Claimant had the respiratory capacity to perform underground coal mining work because of the results of the lung function test and blood gases, which exceeded the minimum federal criteria. *Id.* at 8.

Dr. Broudy stated that Dr. Simpao's pulmonary function test was invalidated, and the valid studies showed mild obstruction. (EX 1 at 8). He stated that the mild obstruction did not support pulmonary disability. *Id.* at 9. Moreover, he found that the blood gas studies were normal or showed mild hypoxemia. *Id.* He explained that blood gas tests were performed to determine the gas exchange function of the lungs, which test how well the lungs are removing carbon dioxide from the blood and how well oxygen is being transferred from the lungs into the blood. *Id.* He stated that there were some validity problems with the October 16th blood gases (referencing the DOL arterial blood gases of October 16, 2001, that were invalidated by Dr. Burki) but he noted that the pO2 (which measures the amount of oxygen dissolved in the blood) was normal. *Id.* He stated that the change from the February to October ABGs could possibly be caused by worsening of a chronic condition or an acute situation causing a transient reduction in the pO2, but that result would not be expected within a matter of months for a chronic condition such as coal workers' pneumoconiosis.[19] *Id.* at 10. He further stated that the latter blood gases were still above the federal black lung disability criteria. *Id.*

[19] This discussion by Dr. Broudy is confusing due either to a transcription error, a misstatement by the questioner, or a reference to inadmissible evidence. The questioner references "a study which had been performed some months prior to October the 16th, on October the 5th, 2002." (EX 1 at 10). No such study appears in the record and the October 16 study that does appear in the record was conducted in 2001, with another study conducted on October 25, 2001 and an earlier study performed on October 18, 2000; the last study was performed on February 5, 2002.

He explained that hypoxemia was a reduction in the amount of oxygen in the blood. (EX 1 at 11). He stated that hypoxemia does not necessarily equal a pulmonary disability and that there can still be satisfactory saturation of hemoglobin with oxygen despite an abnormal oxygen pressure. *Id.*

Dr. Broudy concluded that Claimant does not have pneumoconiosis or any other pulmonary condition attributable to coal dust exposure based upon his review of the records. (EX 1 at 12). He found that cigarette smoking was the cause of the pulmonary dysfunction shown in the pulmonary function test, based on the smoking history, the characteristic of the obstructive airway disease, and the hypoxemia. *Id.* He explained that the characteristic he was referring to was the fact most CWP cases cause restrictive impairment as opposed to obstructive, as seen in this case. *Id.* at 12-13. He stated that inhalation of cigarette smoke is more noxious than inhalation of coal dust. *Id.* at 13.

In addition, he explained that he also found that Claimant has bronchial asthma based upon the fact he has obstructive airway disease and responded to a bronchodilator. (EX 1 at 13). He stated that the asthma did not result from coal dust exposure or pneumoconiosis but was a disease of the general population. *Id.* at 13-14. He stated that the COPD and bronchial asthma were not aggravated or contributed to by the coal dust exposure. *Id.* at 14. He concluded his direct testimony by stating that all opinions were based upon a reasonable degree of medical certainty. *Id.* at 15.

On cross-examination, he stated that Claimant had a sufficient work history for the development of pneumoconiosis. (EX 1 at 15). He stated that Claimant's chief complaint with regard to breathing was dyspnea on exertion. *Id.* at 16. He stated that coal dust or CWP can cause an obstructive impairment. *Id.* He stated that he did not contemporaneously examine the Claimant but that he had examined him back in 1994. *Id.* at 16. He explained that doctors use the American Thoracic Society criteria for validity to examine the tracings and determine the validity of the pulmonary function studies. *Id.* at 17. He stated that he was unable to definitely invalidate the studies by Dr. Simpao based upon his review of the tracings during the deposition, despite Dr. Burki's invalidation of them, and he noted that the results [of the October 16, 2001 test] were only slightly lower than Dr. Westerfield got nine days later. *Id.* at 17-18.

On re-direct examination, Dr. Broudy discussed his examination of the Claimant back in 1994. (EX 1 at 18). However, the testimony relating to this portion of the deposition will not be summarized or considered in this decision because it was stricken from evidence, as stated below.

Treatment Records

The following treatment records have also been submitted:

- 4/1/99 – X-ray Report from Knox County Hospital: Bronchitic changes with peribronchial thickening. No focal infiltrate is noted.
- 4/1/99 - Echocardiogram with an impression of left ventricular diastolic dysfunction.

- 6/9/00- X-Ray Report from Knox County Hospital: interstitial scarring is noted with minimal peribronchial thickening. No active focal infiltrate was found.
- 6/14/00- Echocardiography Report: Listed diagnoses of Dyspnea and COPD by history. Left atrium enlargement and left ventricle dysfunction found. Mild mitral regurgitation. The consulting cardiologist, Dr. Anatha L. Krishna, stated that the findings suggested possible hypertensive heart disease.
- 7/6/00 – PFTs and ABG from Knox County Hospital: Summarized under Medical Evidence section.
- 7/8/00- Dr. Mirella Ducu's letter: she stated that Claimant has been her patient since February 9, 1999. She diagnosed COPD-Black Lung, resulting in chronic cough, dyspnea on exertion, orthopnea and paroxysmal nocturnal dyspnea. In addition, she stated that Claimant had been unsuccessfully treated for dyspnea with inhalers and worked up for heart failure without improvement. She concluded that the major cause of his symptoms was COPD-Black Lung and he was 100% totally and permanently disabled because of pneumoconiosis.

Background and Employment History

Claimant was the only witness to testify at the hearing. He was a credible witness but he had difficulty recalling dates and was not a good historian. Claimant testified that he was born in July 1945 and had been married to his wife, Carolyn, for about 30 years. (Tr. 8).

Regarding coal mining experience, Claimant stated that he was "mostly an airman" during his last coal mine employment with Westerman Coal, which ended in November of 1989.[20] *Id.* at 9. As an air man, he would take a curtain to the area where the coal had been shot, which was smoky, and he would air it out so that the deep divers could come in and remove the coal from the mine. *Id.* at 9. In his Description of Coal Mine Work form, Claimant described this employment as "General mine labor" requiring lifting 50 to 75 pounds, several times per day, and requiring that he stand between 8 and 12 hours. (DX 4).

Claimant testified that he first began working on a "hogger" (sic) for Daryl McNeil but he could not recall the specific year. (Tr. 10-11). After his memory was refreshed from Social Security Earning Records, he stated that he was employed for McNeil from 1971 to 1972. *Id.* at 11. He testified that his job at McNeil was above ground work and consisted of picking slate off the conveyor belt. *Id.* at 12. He stated that he could not recall his employment with Triex Excavating [which was listed on his Social Security earnings record in 1977 (DX 6) and was listed on his coal mine history form as coal mine employment from 1977 to 1978 (DX 3)]. (Tr. 13.) However, he did recall his employment with Premco (mistranscribed as Primco) Coal Company from 1979 to 1980. *Id.* At Premco, he scrapped the face of the mine and cleaned it in preparation for drilling in order to shoot the coal out. *Id.* He stated that the work at Premco was underground work. *Id.* at 13-14. He stated that he worked for Premco for a full year at least. *Id.* at 14. Thereafter, he worked for Cee Jay Inc. in 1983, building timbers, which was also underground coal mine work. *Id.* at 15-16. He next worked for Jay Brent Coal, which had the same owner, from 1983 to 1984, where he did underground work of scrapping and cleaning up

[20] The transcript stated "November of 1999" for the last coal mine employment. This date is a transcription error, because both the Social Security Records and later testimony indicates the year of 1989. (DX 6); (Tr. 15).

around the face of the mine, setting timbers, and rock dusting. *Id.* at 14-16. In 1984, he became employed with Westerman Coal [Employer] as an airman, and he continued his employment there until November 1989. (Tr. 9, 15). He also stated that he had other coal mine employment but was paid in cash with no Social Security earning records. *Id.* at 18.

Claimant testified as to his understanding that he has black lung and heart problems, as well as high blood pressure, hardening of the back side of the heart, and high cholesterol. (Tr. 18, 21). He also stated that he experiences swelling in his feet and ankles. *Id.* at 25. However, he has not been diagnosed with congestive heart failure. *Id.* at 26. He stated that he is unable to do anything hardly, he has coughing and smothering problems, and he has to sleep on three pillows at night. *Id.* at 19. For the last four or five years, he has been prescribed inhalers (Albuterol and Proventil) for his breathing. *Id.* In addition, he has a nebulizer at home to use as needed. *Id.* at 20. He has trouble walking and performing other activities due to shortness of breath. *Id.* at 21-22. He stated that he has been hospitalized for breathing problems. *Id.* at 23.

On cross-examination, he testified that that he could not recall the coal companies after 1977 that did not withhold Social Security from his pay checks. (Tr. 24). He stated that McNeil Coal Company, C.J Bent, and Westerman all paid Social Security payments. *Id.* However, upon my questioning, he estimated that he worked for about two to three years for companies that did not withhold Social Security payments, which resulted in those Employers not being listed on his Social Security Records. *Id.* at 27.

I find that Claimant has established a total of ten and three quarters years of coal mine employment extending over an 18-year period, from 1972 to 1989. My review of the Social Security records, considered in the context of Claimant's testimony and the other evidence of record, substantiates a total of eight and three quarters years of qualifying coal mine employment, and I have credited him with another two years based upon his credible testimony about the coal mine employers that paid him in cash.[21] (DX 6). In so finding, I acknowledge that the Claimant may have had additional coal mine employment but find insufficient evidence to credit him with more.

Regarding Claimant's smoking history, the recorded histories are somewhat inconsistent and Claimant did not testify on that issue. The recent (October 2001) medical report of Dr. Simpao indicates that Claimant smoked for eleven years, between 1964 and 1975, at a rate of one pack of cigarettes per day, which would amount to 11 pack years. Similarly, in his October 2000 report, Dr. Baker recorded a history of smoking for ten to twelve years at a rate of one pack per day, but he went on to state that Claimant stopped smoking 15 years prior to the examination [1973/1975 to 1985]. However, Dr. Baker's earlier (November 1997) report recorded a smoking history of 22 to 23 years ending 8 to 9 years before [from 1965/1967 to 1988/1989]. In October 2001, Dr. Westerfield recorded a history of smoking from age 18 [1963/1964] to age 36

[21] Claimant worked at McNeil Coal Co., Inc. for one quarter in 1971 and two quarters in 1972 and, after working for non-coal-mine employers (with the possible exception of Triex Excavating in 1977) from 1973 to 1978, he worked at least one year for Premco Coal Inc. in 1979 and 1980. (DX 6, Tr. at 14). No earnings are shown on the Social Security records for 1976, 1981, and 1982. *Id.* Claimant worked for coal mine employers (Cee Jay, Inc., Jay Brent Coal, and Westerman Coal) from 1983 through 1989 (seven years). *Id.* Claimant testified that once he started working in the coal industry he stayed with coal mine employment. (Tr. at 15.)

[1981/1982] at a rate of one pack per day on the printed form; similarly, he recorded a history of smoking one pack per day for 18 years, quitting 20 years before [1981] in the typed report. Thus, Claimant began smoking some time between 1963 and 1967 and stopped smoking some time between 1975 and 1988, for a smoking history ranging between 8 and 25 pack years. These discrepancies suggest that Claimant is not a good historian and, coupled with his difficulty recalling dates, I give more credence to his earlier account than his later attempts to reconstruct his smoking history. However, as there is only a four year period (from 1997 to 2001) over which the four examinations were conducted, I will take into consideration all of the histories. Based upon the above, I find that 18 pack years (from the mid 1960's to the mid 1980's) is a reasonable estimate.

Discussion and Analysis

Evidentiary Limitations

My consideration of the medical evidence is limited under the regulations, which apply evidentiary limitations to all claims filed after January 19, 2001. 20 C.F.R. §725.414. Section 725.414, in conjunction with Section 725.456(b)(1), sets limits on the amount of specific types of medical evidence that the parties can submit into the record. *Dempsey v. Sewell Coal Co.,* 23 B.L.R. 1-47 (2004) (en banc), BRB No. 03-0615 BLA (June 28, 2004) (en banc) (slip op. at 3), *citing* 20 C.F.R. §§725.414; 725.456(b)(1). Under section 725.414, the claimant and the responsible operator may each "submit, in support of its affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, no more than one report of an autopsy, no more than one report of each biopsy, and no more than two medical reports." *Id., citing* 20 C.F.R. §725.414(a)(2)(i),(a)(3)(i). In rebuttal of the case presented by the opposing party, each party may submit "no more than one physician's interpretation of each chest X-ray, pulmonary function test, arterial blood gas study, autopsy or biopsy submitted by" the opposing party "and by the Director pursuant to §725.406." *Id., citing* 20 C.F.R. §725.414(a)(2)(ii), (a)(3)(ii). Following rebuttal, each party may submit "an additional statement from the physician who originally interpreted the chest X-ray or administered the objective testing," and, where a medical report is undermined by rebuttal evidence, "an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence." *Id.* "Notwithstanding the limitations" of section 725.414(a)(2),(a)(3), "any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence." *Id., citing* 20 C.F.R. §725.414(a)(4). Medical evidence that exceeds the limitations of Section 725.414 "shall not be admitted into the hearing record in the absence of good cause." *Id., citing* 20 C.F.R. §725.456(b)(1).

The parties cannot waive the evidentiary limitations, which are mandatory and therefore not subject to waiver. *Phillips v. Westmoreland Coal Co.,* 2002-BLA-05289, BRB No. 04-0379 BLA (BRB Jan. 27, 2005) (unpub.) (slip op. at 6).

The Benefits Review Board discussed the operation of these limitations in its en banc decision in *Dempsey, supra.* First, the Board found that it was error to exclude CT scan evidence

because it was not covered by the evidentiary limitations and instead could be considered "other medical evidence." *Dempsey* at 5; s*ee* 20 C.F.R. § 718.107(a) (allowing consideration of medical evidence not specifically addressed by the regulations). Second, the Board found that it was error to exclude pulmonary function tests and arterial blood gases derived from a claimant's medical records simply because they had been proffered for the purpose of exceeding the evidentiary limitations. *Dempsey* at 5.

In this case, the x-ray evidence, pulmonary function test and arterial blood gases are in compliance with the regulations; however, the medical reports in the record exceed the evidentiary limitations. Claimant designated two examination reports by Dr. Baker dated May 29, 1997 and October 18, 2000 as his initial evidence, and Employer designated the August 22, 2003 review report by Dr. Broudy and September 16, 2002 examination report by Dr. Westerfield as its initial evidence. The Director submitted the October 16, 2001 report of Dr. Simpao as the DOL report and also submitted repeat testing conducted on February 5, 2002; however, the Director did not file a Designation of Evidence/BLBA Evidence Summary Form. Nevertheless, the DOL examination results are appropriately considered.

At the hearing, all of the Director's Exhibits (DX 1 to DX 36) were admitted into evidence with no objection by the parties. However, the Director's Exhibits included two additional medical reports that were not designated by either party. (DX 29). As stated above, Claimant designated two reports as evidence on their Evidence Summary Form; however, the remaining medical report dated October 5, 2000 by Dr. Baker (which actually related to the 1997 examination) was not designated as evidence by either party but remains in the record. Likewise, the Director's Exhibits also include a medical report dated October 25, 2001 by Dr. Westerfield but the report was not designated by either party in this proceeding. The Director's Exhibits are also subject to the evidentiary limitations, and these two additional medical reports technically exceed the evidentiary limits. However, inasmuch as the additional reports are by the same physicians, relate to admissible examinations by those physicians, and are essentially cumulative of the other reports by these physicians, they will remain in the record and do not warrant further discussion.

More importantly, Dr. Broudy's medical report dated August 22, 2003 and his deposition of September 5, 2003 referenced inadmissible evidence. In the report, he stated that "although it is not part of the evidence you have asked me to review, our records indicate that Mr. Stamper was here to see me for evaluation on July 6, 1994." Thereafter, he summarized the findings of that medical visit. He also discussed the x-ray findings, pulmonary function tests, arterial blood gases, and smoking history from that examination at his deposition. The July 6, 1994 medical report by Dr. Broudy was not designated by any party, and as stated above, each party has designated the maximum number of medical reports allowed under the regulations. Unlike the reports by Drs. Baker and Westerfield, which are limited to data already of record, the report by Dr. Broudy references inadmissible clinical data from the 1994 examination. Thus, the findings from the July 6, 1994 report and discussion of that report are **STRICKEN** as are any references thereto. However, inasmuch as the report and deposition are not inextricably intertwined with the 1994 examination report, they will not be excluded from evidence in their entirety but will be given less weight to the extent that inadmissible evidence was relied upon, as discussed below.

Similarly, Dr. Westerfield referenced his own interpretation of an October 19, 1994 x-ray at his deposition. That x-ray interpretation is not part of the record and has not been designated by any party. Thus, the findings relating to that x-ray and discussion thereof are **STRICKEN** as are any references thereto. However, Dr. Westerfield's report and deposition will not be excluded from evidence but will be given less weight to the extent that inadmissible evidence was relied upon, for the reasons set forth below.

Although the above reports and depositions referred to inadmissible evidence, they will still be considered as evidence to the extent the findings in the report relied upon other admissible evidence. According to §718.414(a)(3)(i), which states the following:

> "any chest x-ray interpretations, pulmonary function test results, blood gas studies, autopsy report, biopsy report, and physicians' opinions that appear in a medical report must each be admissible under this paragraph or paragraph (a)(4) of this section."

As noted in *Dempsey,* the regulations do not specify what is to be done with a medical report or testimony that references an inadmissible x-ray. *Dempsey v. Sewell Coal Co.,* 21 BLR --, BRB No. 03-0615 BLA (June 28, 2004) (en banc). Further, the Board held that the administrative law judge did not abuse his discretion in declining to consider a physician's opinion which he found was "inextricably tied" to an inadmissible x-ray reading. *Id.* at 15-16. I do not find that either Dr. Broudy's or Dr. Westerfield's medical opinion is inextricably tied to the excluded medical evidence insofar as their conclusions were based on other factors, including contemporaneous admissible medical evidence. *See* 20 C.F.R. §725.414(a)(2)(ii). Therefore, their medical reports and deposition transcripts can be considered as credible evidence, and their reliance upon inadmissible evidence with go to the weight of their medical opinions.

The medical treatment records by Dr. Ducu (DX 25) are not subject to the evidentiary limitations, because they qualify as treatment records. The treatment records include pulmonary function testing and arterial blood gases dated July 6, 2000. As stated above, the Board found that it was error to exclude pulmonary function tests and arterial blood gases derived from a claimant's medical records because they exceed the evidentiary limits. *Dempsey* at 5. Thus, these records will be considered.

Merits of the Claim

To prevail in a claim for Black Lung benefits, a claimant miner must establish that he or she suffers from pneumoconiosis; that the pneumoconiosis arose out of coal mine employment; that he or she is totally disabled, as defined in section 718.204; and that the total disability is due to pneumoconiosis. 20 C.F.R. §§718.202 to 718.204. The Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence is evenly balanced, the claimant must lose. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 281 (1994). In *Greenwich Collieries*, the Court invalidated the "true doubt" rule, which gave the benefit of the doubt to claimants. *Id.* Thus, in order to prevail in a black lung case, a claimant must establish each element by a preponderance of the evidence.

Existence of Pneumoconiosis

The regulations (both in their original form and as revised effective January 19, 2001) provide several means of establishing the existence of pneumoconiosis: (1) a chest x-ray meeting criteria set forth in 20 C.F.R. §718.102, and in the event of conflicting x-ray reports, consideration is to be given to the radiological qualifications of the persons interpreting x-ray reports; (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. §718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" set forth in 20 C.F.R. §718.304 (or two other presumptions set forth in §718.305 and §718.306); or (4) a determination of the existence of pneumoconiosis as defined in §718.201 made by a physician exercising sound judgment, based upon objective medical evidence and supported by a reasoned medical opinion. 20 C.F.R. §718.202(a) (1)-(4). Under section 718.107, other medical evidence, and specifically the results of medically acceptable tests and procedures which tend to demonstrate the presence or absence of pneumoconiosis, may be submitted and considered. At least two United States Courts of Appeals (the Fourth Circuit and the Eleventh Circuit) have held that all of the evidence from section 718.202 should be weighed together in determining whether a miner suffers from pneumoconiosis. *See, e.g., U.S. Steel Mining Co. v. Director, OWCP, [Jones],* 386 F.3d 977 (11th Cir. 2004); *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 208-209 (4th Cir. 2000). *But see Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (en banc) (noting "the Sixth Circuit has often approved the independent application of the subsections of Section 718.202(a) to determine whether claimant has established the existence of pneumoconiosis.")

Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149 (1989) (en banc); *Casella v. Kaiser Steel Corp*., 9 B.L.R. 1-131 (1986). In the case of x-ray evidence, more recent positive evidence may be credited over older negative evidence. *Chaffin v. Peter Cave Coal Co.,* 22 BLR 1-294, 1-302 (BRB 2003).

In the recent amendments to the regulations, the definition of pneumoconiosis in section 718.201 has been amended to provide for "clinical" and "legal" pneumoconiosis and to acknowledge the latency and progressiveness of the disease. Legal pneumoconiosis is defined as "any chronic lung disease arising out of coal mine employment." 20 C.F.R. §718.201(a). The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. §718.201(b). Notably, in amending the regulations, the Department of Labor discussed the strong epidemiological evidence supporting an association between coal dust exposure and obstructive pulmonary disability (65 Fed. Reg. 79937-79945 (Dec. 20, 2000)), but it nevertheless chose to require that each individual claimant establish by a preponderance of the evidence that such an association occurred in that individual's case. *Id.* at 79938.

X-Ray Evidence. The x-ray evidence submitted in connection with the instant case is summarized above. In determining the existence of pneumoconiosis based on chest x-ray

evidence, "where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." 20 C.F.R. §718.202(a) (1). The Board has held that it is proper to accord greater weight to the interpretation of a B-reader or Board-certified Radiologist over that of a physician without these specialized qualifications. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-qualified B-reader and Board-certified radiologist may be accorded greater weight than that of a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984).

There are conflicting interpretations in the record with two negative x-ray readings (dated October 19, 1994 and October 25, 2001) and four positive readings (dated October 29, 1997; October 18, 2000; October 16, 2001; October 25, 2001). In regards to numerical superiority, the evidence supports a finding of pneumoconiosis with four positive readings by three readers and two negative readings by two readers.

The regulations provide that in the event of conflicting x-ray reports, consideration is to be given to the radiological qualifications of the persons interpreting x-ray reports. The two negative readings are by one B-Reader physician (Westerfield) and one physician with both B-reader and board certified radiologist qualifications (Halbert). Of the positive readings, two are by a B-reader physician (Baker), one is by a physician who is both a B-Reader and a board certified radiologist (Alexander), and the remaining positive x-ray interpretation was by an A-Reader (Dr. Simpao). Only the x-ray dated October 25, 2001 was interpreted by two physicians. Dr. Westerfield made a completely negative finding while Dr. Alexander found pneumoconiosis. I will give greater weight to Dr. Alexander's interpretation, because he is both a board certified radiologist and a B-reader while Dr. Westerfield only holds B-Reader qualifications. Thus, I find, taking into consideration the qualifications of the readers, that the October 19, 1994 x-ray may be deemed to be negative and the remaining x-rays may be deemed to be positive for pneumoconiosis.

Moreover, the October 25, 2001 x-ray is the most recent x-ray of record and, because it is positive, it should be given greater weight due to the progressive nature of pneumoconiosis. *Chaffin, supra*. The first x-ray of record is dated October 19, 1994, which is seven years prior to the October 2001 reading. The October 2001 provides a more accurate description of the Claimant's present condition. For such reasons, I accord greater weight to the positive x-ray finding by Dr. Alexander.

In summary, the positive readings outweigh the negative readings, both numerically and qualitatively The October 25, 2001 x-ray is the only x-ray in record that was read by two physicians, and the more qualified B-Reader and board certified radiologist, Dr. Alexander, found pneumoconiosis. Thus, the latest x-ray of record was found to be positive for the disease by the most qualified reader. Although an equally qualified reader, Dr. Halbert, found an earlier x-ray to be negative, his interpretation related to an x-ray taken in 1994 and Dr. Alexander was the only dually qualified reader to read a later x-ray. The remaining readings were positive. For such reasons, I find that Claimant has meet the preponderance of the x-ray evidence standard in establishing pneumoconiosis, and Claimant prevails under 20 C.F.R. §718.202(a)(1).

Autopsy or Biopsy Evidence. There is no pathological evidence of record. I therefore find that the Claimant has not established that he suffers from pneumoconiosis under 20 C.F.R. §718.202(a)(2).

Complicated Pneumoconiosis and Other Presumptions. A finding of opacities of a size that would qualify as "complicated pneumoconiosis" under 20 C.F.R. § 718.304 results in an irrebuttable presumption of total disability. As there is no evidence of complicated pneumoconiosis under either the old or new evidence, the section 718.304 presumption is inapplicable. The additional presumptions described in section 718.202(a)(3), which are set forth in 20 C.F.R. § 718.305 and 20 C.F.R. § 718.306 are also inapplicable, inter alia, because they do not apply to claims filed after January 1, 1982 or June 30, 1982, respectively, and section 718.306 only applies to death claims. Thus, Claimant has failed to establish the presence of pneumoconiosis under 20 C.F.R. § 718.202(a)(3).

Medical Opinions on Pneumoconiosis. In addition to the medical records, discussed below, the medical opinions of four doctors (Dr. Glen Baker; Dr. Valentino Simpao; Dr. B.T. Westerfield: and Dr. Bruce Broudy) addressed the issue of whether the Claimant suffers from pneumoconiosis. All four physicians are board certified in internal medicine with a subspecialty in pulmonary diseases and are highly qualified to express opinions on the issue of pneumoconiosis. Drs. Baker, Simpao, and Westerfield examined the Claimant in connection with this claim. Although Dr. Broudy examined the Claimant in 1994, that examination report is not of record and references to it have been stricken. Each of these physicians prepared one or more reports and Drs. Westerfield and Broudy had their depositions taken. Drs. Baker and Simpao found the Claimant to be suffering from pneumoconiosis while Drs. Westerfield and Broudy found the contrary.

In reviewing the reports of these physicians, I will take into consideration the extent to which their opinions are reasoned and documented. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (BRB 1987) (explaining that a "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis, and a "reasoned" opinion is one in which the underlying documentation is adequate to support the physician's conclusions). In addition, I will take into consideration the credentials of the physicians, which may have some bearing on the reliability of their opinions. *See, e.g., Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 21 B.L.R. 2-323 (4th Cir. 1998)

The report by Dr. Simpao, while documented, is lacking in some respects. While the report included a complete history, detailed physical findings, and a summary of test results, it failed to explain and support the conclusions reached. In this regard, when asked whether the Claimant had an occupational lung disease caused by his coal mine employment, Dr. Simpao states that he based his diagnosis on the chest x-ray, pulmonary function test, physical findings, and symptomatology. The pulmonary function studies were later invalidated by Dr. Burki, but Dr. Broudy found the pulmonary function tests to be valid. Although Dr. Simpao relied upon his own reading of the x-ray and he is only qualified as an A-reader, I have found the x-ray evidence as a whole to be positive for pneumoconiosis and I do not find that to be a basis for discrediting his report. However, while the report clearly recounts physical findings and symptoms, Dr.

Simpao has not explained which of those findings and symptoms supported his conclusions. Moreover, he has relied upon an underestimated smoking history of 11 years while I have found that 18 years is a more realistic estimate, for the reasons set forth above, and he has also misstated the remoteness of that history (1975 versus the mid 1980's). While Dr. Simpao's report supports a finding of clinical pneumoconiosis and includes some objective medical evidence supporting the conclusions reached, it lacks sufficient analysis and reasoning to be entitled to controlling weight.

The reports submitted by Dr. Baker were well documented and were better reasoned. I place more weight on the October 18, 2000 report because it is based upon a more complete picture of the Claimant's current condition, in view of the progressive nature of pneumoconiosis. That report recounted the Claimant's progressive breathing problems associated with cough, sputum, and wheezing; referred to the abnormal x-ray findings; and stated a history of 11 years of coal dust exposure proven, with 14 to 15 years claimed. Dr. Baker, a B-reader, found the Claimant to have simple coal worker's pneumoconiosis based upon his readings of 1997 and 2000 x-rays. As noted above, I have found the x-ray evidence as a whole to support a finding of pneumoconiosis. Moreover, I have found 10 3/4 years of coal mine employment over an 18-year period established and I find the discrepancy between 10 3/4 and 11 years to be inconsequential. Dr. Baker stated the following in this October 18, 2000 report:

> Certainly, Mr. Stamper has Coal Workers' Pneumoconiosis, mild resting arterial hypoxemia, chronic obstructive airway disease with moderate obstructive defect and chronic bronchitis. These conditions are due at least in part if not significantly so to his coal dust exposure. He has a history of smoking only 10-12 years and we normally would think a 15 pack year history of smoking would be necessary to implicate his smoking history as contributory to his obstructive airway disease. Also, he quit smoking 15 years ago and has not smoked since that time and his symptoms have only been present for 10-12 years. It is therefore felt that his coal dust has a significant part to play in the development of his airway disease in addition to his coal workers' pneumoconiosis, chronic bronchitis, and resting arterial hypoxemia.

(DX 25). I find Dr. Baker's report to be documented. Specifically, he has relied upon the x-ray findings, coal mining history, hypoxemia on arterial blood gases, nature and onset of symptoms, and inconsequential, remote smoking history. While the smoking history that he relied upon is likely on the low side (11 years versus the 18 years I found) that factor alone is insufficient to invalidate his opinion, which is also based upon the remoteness of the history and onset of symptomatology (which he accurately recorded); however, his opinion is entitled to less weight because of it, particularly in view of his statement that 15 pack years would be required for smoking to be a factor. Dr. Baker's statement that Claimant has "Coal Workers' Pneumoconiosis, mild resting arterial hypoxemia, chronic obstructive airway disease with moderate obstructive defect and chronic bronchitis . . . due at least in part if not significantly so to his coal dust exposure" establishes a diagnosis of "clinical pneumoconiosis"; however, he has not stated unequivocally that the conditions besides CWP are significantly caused by, or substantially aggravated by, exposure to coal mine dust, as required to satisfy the definition of "legal pneumoconiosis."

Dr. Westerfield's report, while including detailed findings based upon his examination of the Claimant, provides limited analysis, and while the deposition testimony thoroughly explained the basis for his findings, it was flawed. Dr. Westerfield's report is entitled to less weight due to several deficiencies, and in particular the following: (1) Dr. Westerfield relied upon his own negative interpretation of the x-ray taken during his examination but I have found that the x-ray evidence, including the sole reading by the most qualified reader related to the same x-ray, to be positive for pneumoconiosis. (2) Dr. Westerfield relied upon his own interpretation of a 1994 x-ray even though that reading was inadmissible (although a negative interpretation by a dually qualified reader was of record); however, that interpretation was also inconsistent with my finding based upon the x-ray evidence as a whole. (3) Dr. Westerfield's opinion is based in part upon his assumption that simple coal worker's pneumoconiosis does not progress, which is contrary to the regulations appearing at section 718.201(c), which state that pneumoconiosis is a latent and progressive disease which may first become detectable after cessation of coal mine employment. (4) Dr. Westerfield stated that there was no evidence of pneumoconiosis but then went on to acknowledge that the Claimant had a restrictive ventilatory defect and sufficient exposure to coal dust to contract CWP, and that CWP was a classically restrictive abnormality.[22] (5) Although he stated that there was no evidence of pneumoconiosis, he also noted abnormal arterial blood gases and shortness of breath.

Dr. Broudy's report and deposition testimony, while providing sufficient analysis, also are deficient for several reasons. (1) Dr. Broudy's opinion is given less weight because he relied in part upon inadmissible evidence, and specifically his 1994 examination of the Claimant, which has been excluded from consideration, and he did not otherwise examine the Claimant. (2) Dr. Broudy relied upon negative interpretations of the x-rays by himself and other B-readers, even though his own x-ray readings were inadmissible and I have found the x-ray evidence as a whole to be positive for pneumoconiosis. (3) Dr. Broudy has relied in part upon the fact that the Claimant has an obstructive impairment to exclude coal mine dust as a factor, even though the regulations acknowledge that an obstructive defect can be caused by coal mine dust, and, more importantly, the pulmonary function tests showed a combined restrictive and obstructive defect.

It is the Claimant's burden of proof to prove the existence of pneumoconiosis. Here, while the reports of Drs. Simpao and Baker support a finding of coal workers' pneumoconiosis ("clinical pneumoconiosis"), I find that Claimant has failed to meet his burden of establishing that his COPD, chronic bronchitis, or other lung conditions besides CWP were significantly related to or substantially aggravated by coal mine dust exposure ("legal pneumoconiosis") through Dr. Simpao's and Dr. Baker's reports. Those reports fall short of meeting the regulatory requirement and their analysis on the issue is sparse and dependent upon an underestimated smoking history. The fact that the opinions of Dr. Westerfield and Dr. Broudy are also flawed does not assist the Claimant. As a whole, I find that the preponderance of the medical opinion evidence does not support a finding of legal pneumoconiosis; however, it supports a finding of clinical pneumoconiosis as I have found based upon the x-ray evidence.

[22] While Dr. Westerfield appeared to be implying that an obstructive defect cannot be attributable to CWP, he did not state so specifically, noting only that it was classically a restrictive disorder.

Other Evidence of Pneumoconiosis. There is other evidence of record on the issue of pneumoconiosis consisting of Claimant's treatment records from Dr. Mirella Ducu, including two x-ray interpretations, an echocardiography consultation, and a medical report by Dr. Ducu.

The two x-ray interpretations were by hospital radiologist Sankar Lakshman. A chest x-ray taken on April 1, 1999 was found to show bronchitic changes with minimal peribronchial thickening but no focal infiltrate, while the June 8, 2000 x-ray was interpreted as showing interstitial scarring with minimal peribronchial thickening and no focal infiltrate. These reports do not diagnose Claimant with pneumoconiosis nor exclude a diagnosis of pneumoconiosis and add little to the x-ray evidence of record.

While the echocardiography consultation listed a diagnosis of COPD by history, it did not discuss the etiology of the condition. That report therefore adds little to the equation.

In addition, Mirella Ducu, M.D., issued a report dated July 18, 2000, in which she states the Claimant had been her patient since February 9, 1999 and was suffering from COPD- Black Lung, which was responsible for most of his symptoms. She explained that she had eliminated other conditions as possibly responsible for Claimant's condition based upon an unsuccessful workup for heart failure and his lack of response to inhalers (Proventil and Atrovent). Thus, she explained the basis for associating the Claimant's symptomatology with black lung and COPD. However, she did not specifically address the basis for her diagnosis of black lung or the etiology of Claimant's COPD. On the issue of pneumoconiosis, Dr. Ducu's letter was conclusory and failed to provide objective medical evidence to support her diagnosis. Dr. Ducu's opinion may be given special consideration due to her status as Claimant's treating physician pursuant to §718.104(d). Under §718.104(d), in weighing the medical evidence, consideration should be given to the nature, duration, frequency, and extent of the physician's relationship with the Miner as his treating physician. Here, the treating relationship was for 15 months (from February 1999 to July 2000) prior to the opinion, which is significant but not extensive, and the limited treatment records provided do not reflect treatment with any frequency.. However, Dr. Ducu treated the Claimant for his respiratory condition as well as having him worked up for possible heart failure. Weighing the factors under section 718.104(d), I find that this Dr. Ducu's report has probative value but is not entitled to controlling weight. The report does not establish legal pneumoconiosis, although it provides further support for a finding of clinical pneumoconiosis.

All Evidence on Pneumoconiosis. Taking into consideration all of the evidence on the issue of the existence of pneumoconiosis, I find that the Claimant has established clinical pneumoconiosis, but not legal pneumoconiosis, based upon the evidence of record considered as a whole. Although Claimant has proved the existence of the clinical pneumoconiosis through x-ray and other evidence, he failed to satisfy the burden of proof with respect to the etiology of his COPD, bronchitis, and asthma. However, inasmuch as he has established clinical pneumoconiosis, he has established this element of his claim.

Causal Relationship With Coal Mine Employment

In order for a claimant to be found eligible for benefits under the Act, it must be determined that the miner's pneumoconiosis arose at least in part out of coal mine employment.

20 C.F.R. §718.203 (a). If a miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. §718.203(b). As stated above, I found that Claimant has pneumoconiosis, and he has established 10 3/4 years of coal mine employment. Thus, he is entitled to the presumption that his coal mine employment at least in part caused the disease, and this element of entitlement under §718.203 is satisfied. I also find that the presumption has not been rebutted based upon the medical evidence summarized above.

Total Disability

The regulations as amended provide that a claimant can establish total disability by showing pneumoconiosis prevented the miner "[f]rom performing his or her usual coal mine work," and "[f]rom engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." 20 C.F.R. §718.204(b)(1). Where, as here, there is no evidence of complicated pneumoconiosis, total disability may be established by pulmonary function tests, arterial blood gas tests, evidence of cor pulmonale with right sided congestive heart failure, or physicians' reasoned medical opinions, based on medically acceptable clinical and laboratory diagnostic techniques, to the effect that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in the miner's previous coal mine employment or comparable work. 20 C.F.R. §718.204(b)(2). For a living miner's claim, it may not be established solely by the miner's testimony or statements. 20 C.F.R. §718.204(d)(5).

Pulmonary function tests. I find that Claimant has established total disability through the pulmonary function tests, which are summarized in tabular form above. Under subparagraph (i) of section 718.204(b)(2), total disability is established if the FEV1 value is equal to or less than the values set forth in the pertinent tables in 20 C.F.R. Part 718, Appendix B, for the miner's age, sex and height, if in addition, the tests reveal qualifying FVC or MVV values under the tables, or an FEV1/FVC ratio of less than 55%. Here, there were six PFTs, only two of which (Dr. Ducu's tests in July 2000 and Dr. Westerfield's in October 2001) included post-bronchodilator values.

- The first test, by Dr. Baker in October 1997, produced a qualifying FEV1, but the test overall was nonqualifying; however, no MVV was recorded.
- The second test, by Dr. Ducu in July 2000, produced nonqualifying FEV1 values both pre-and post-bronchodilator.
- The four most recent pulmonary function tests (by Dr. Baker in October 2000, by Dr. Westerfield in October 2001, and by Dr. Simpao in October 2001 and February 2002) are qualifying pre-bronchodilator based upon the FEV1 and MVV values; in addition, the FVC value is qualifying on Dr. Simpao's and Dr. Westerfield's October 2001 test (less than 2.89 for a height of 72 inches.)[23]

[23] The recorded heights vary between 71 inches and 73 inches, and I find that the prevalent value of 72 inches is the correct one. The difference between the recorded height of 71 inches and 72 inches would make the pre-bronchodilator FVC value as well as the MVV value qualifying for Dr. Westerfield's test.

- The validity of the tests by Dr. Simpao has been questioned by DOL reviewer Dr. Burki based upon suboptimal effort reflected by the loops (although Dr. Broudy did not find the results to be invalid upon his review of the tracings and Dr. Simpao noted good effort, cooperation, and comprehension on each test). Dr. Simpao interpreted the October 2001 test results as showing "moderate degree restrictive and severe degree obstructive airway disease" and the February 2002 test as showing "moderate degree both restrictive and obstructive airway disease."
- The post bronchodilator values for the October 25, 2001 test by Dr. Westerfield were nonqualifying. Moreover, Dr. Westerfield questioned the validity of the MVV pre bronchodilator due to the Claimant's severe shortness of breath (although the pre-bronchodilator FVC is also qualifying for a height of 72 inches). Dr. Westerfield noted good cooperation and effort by Claimant and in his 2002 report stated that his PFT was valid.[24] Dr. Westerfield stated that this spirometry demonstrates mild obstructive and moderate restrictive respiratory dysfunction with significant improvement following inhaled bronchodilator.
- The validity of Dr. Baker's October 2000 test has not been questioned by anyone. That test (which only included pre-bronchodilator values) produced qualifying values based upon the FEV1 and MVV values. Dr. Baker interpreted the test as showing moderate obstructive ventilatory defect with a mild degree of restriction as well.

Thus, of the six tests, four were qualifying pre-bronchodilator, two were nonqualifying pre-bronchodilator, and two were nonqualifying post-bronchodilator. See 20 C.F.R. §718.204(b)(2)(i); Part 718, Appendix B. The preponderance of the most recent pulmonary function tests were positive for a disabling respiratory impairment based upon the regulatory criteria, but only two tests (by Dr. Baker and Dr. Westerfield) produced qualifying results that can be validated, and Dr. Westerfield's test also produced a nonqualifying value post-bronchodilator. While the consistently nonqualifying post-bronchodilator values may suggest a nonpermanent impairment and that factor may be considered by the reviewing physicians, the regulations do not provide for consideration of post-bronchodilator results over results taken before the administration of a bronchodilator. Accordingly, I find that the pulmonary function tests weigh slightly in favor of a finding of total disability under §718.204(b)(2)(i).

Arterial blood gases. Claimant has not satisfied the burden of proving total disability through arterial blood gas studies under §718.204(b)(2)(ii). The arterial blood gas ("ABG") studies, which are summarized above, are nonqualifying under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix C, with the exception of the October 16, 2001 test, which produced borderline values. However, that test was invalidated by Dr. Burki. It is worth noting that, notwithstanding the nonqualifying values, some of the results were not normal. In this regard, Dr. Baker interpreted both the October 1997 and the October 2000 test results as showing mild resting arterial hypoxemia. Also, Dr. Westerfield noted mild oxygen desaturation with minimal CO2 retention on room air at rest based upon the October 25, 2001 ABG. However, Dr. Simpao found that the February 2002 test results (which were the most recent ones recorded) indicated a normal arterial blood gas. None of the valid tests produced qualifying values. Accordingly, the ABGs do not support a finding of total disability.

[24] Specifically, Dr. Westerfield stated in his September 16, 2002 report that all of the PFTs (with the exception of those by Dr. Simpao, which he did not address) were valid.

Cor pulmonale with right-sided congestive heart failure. There is no evidence of cor pulmonale, so Claimant has not established total disability under section 718.204(b)(2)(iii).

Medical opinion evidence on total disability. I find that Claimant has established total disability through reasoned medical opinions. Where total disability cannot be shown under paragraphs (b)(2)(i), (ii), or (iii) of this section, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may nevertheless be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory findings, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine employment or comparable work. §718.204(b)(2)(iv). Medical opinions of four doctors (Dr. Glen Baker; Dr. Valentino Simpao; Dr. B.T. Westerfield; and Dr. Bruce Broudy) are of record, in addition to the statement from Claimant's treating physician, Dr. Mirella Ducu, in the medical records. Of these, Drs. Baker, Simpao, and Ducu found the Claimant to be totally disabled from his last coal mine employment while Dr. Broudy equivocally suggested that he was not and Dr. Westerfield did not squarely address the issue.

- Based upon his October 1997 examination, Dr. Baker stated that the Claimant had a Class III impairment due to CWP under the Guides to the Evaluation of Permanent Impairment, 4th Edition and also that he was 100% occupationally disabled because the presence of pneumoconiosis requires his removal from the environment causing the condition. In a supplemental report of October 5, 2000 relating to the same examination, Dr. Baker stated his opinion that the Claimant was permanently and totally disabled for work in the coal mining industry. However, later in the report he made it clear that he was recommending that the Claimant not have any exposure to coal dust, rock dust, or any occupational dust exposure in the future. He did not compare the requirements of Claimant's coal mine employment with his capabilities nor did he state that a Class III impairment would prevent the Claimant from performing his last coal mine employment or comparable work. Moreover, a finding that a Miner should avoid occupational exposure is more in the nature of a medical recommendation based upon health concerns and is insufficient to establish total disability from a pulmonary or respiratory condition. *See Taylor v. Evans and Gambrel Company, Inc.*, 12 BLR 1-83 (1988) (advice that a miner should avoid dusty situations is not tantamount to a finding of total disability due to pneumoconiosis). *See also Zimmerman v. Director, OWCP,* 871 F.2d 564, 567, 12 BLR 2-254, 2-258 (6th Cir. 1989) (recommendation that miner not return to underground coal mining because of his silicosis is not equivalent to a finding of total disability). *But see White v. New White Coal Col, Inc.,* 23 B.L.R. 1-1 (2004) (affirming ALJ's finding that similar opinion by Dr. Baker is supportive of claimant's burden of establishing a totally disabling respiratory impairment). Dr. Baker's 1997 examination report and supplemental report related thereto do not establish total disability.
- In Dr. Baker's October 18, 2000 narrative examination report, Dr. Baker again opined that the Claimant had a Class III impairment based upon his pulmonary function findings (again, without comparing that disability to the requirements of Claimant's coal mine job). He also stated, as he had in the prior report, that Claimant had a second impairment based upon the presence of pneumoconiosis which required his removal from exposure to

the dust causing the condition, even if the condition caused no physiological impairment. Like Dr. Baker's 1997 examination report, his 2000 examination report also falls short of establishing total disability under the regulatory requirements. *But cf. White, supra.*

- In Dr. Simpao's October 16, 2001 examination report, after providing detailed findings and referencing an attached occupational history, he opined that the Claimant had "moderate impairment." He went on to state, by checking the appropriate box in a supplemental form, that the Claimant lacked the respiratory capacity to perform the work of a coal miner or comparable work in a dust-free environment. As his rationale for that opinion, he listed "objective findings on the chest X-ray and pulmonary function test along with physical findings and with symptomatology as noted in the report."
- In his form examination report, Dr. Westerfield indicated that the Claimant had an AMA Class II impairment but he did not indicate how that impairment impacted the Claimant's ability to perform his last coal mine work. He also did not squarely address the issue at his deposition. In his September 2002 report, Dr. Westerfield summarized the pulmonary function tests (except for Dr. Simpao's tests), which he found to be valid, and noted that the Claimant had a respiratory impairment which had been stable since 1997 and increasing symptoms; however, he did not squarely address whether the Claimant was totally disabled from a pulmonary or respiratory impairment.
- Dr. Broudy reviewed the evidence of record and indicated in his report that there was no evidence that the Claimant had "any significant pulmonary or respiratory impairment which has arisen from his occupation as a coal worker" (which is more in the nature of an opinion based upon the cause of Claimant's impairment rather than its extent) and he also stated that based upon Dr. Ducu's pulmonary function test findings (which he believed to be the best results) the Claimant would retain the respiratory capacity to perform the work of an underground coal miner or similarly arduous manual labor. However, he did not make such a statement based upon all of the evidence of record and he did not do so at his deposition either. Overall, Dr. Broudy's report is too equivocal to be considered a reasoned medical opinion on the issue of total disability, but it is relevant as rebuttal to Dr. Ducu's medical opinion. Dr. Broudy did not cure the deficiencies at his deposition.
- Dr. Ducu opined in a report of July 18, 2000 that the Claimant was "100% totally and permanently disabled due to symptoms from COPD – pneumoconiosis – Black Lung, including chronic cough, dyspnea on exertion, orthopnea and paroxysmal nocturnal dyspnea," which she had been unsuccessful in treating with Proventil and Atrovent inhalers. She based her findings in part upon contemporaneous clinical data, including a pulmonary function test (addressed by Dr. Broudy, above). She did not discuss the requirements of Claimant's coal mine employment or how the symptoms affected his ability to perform that employment.

Based upon the above, I find that only the reports of Drs. Simpao and Ducu support a finding of total disability and the other reports do not adequately address the issue.[25] Dr. Broudy confined his opinion to a rebuttal of Dr. Ducu's finding of total disability based upon her PFTs and did not squarely address the ultimate issue in his equivocal report or at his deposition. Dr.

[25] In so finding, I recognize that the Benefits Review Board has suggested that an opinion such as Dr. Baker's is adequate to establish total disability. *White v. New White Coal Col, Inc.*, 23 B.L.R. 1-1 (2004). However, inasmuch as I have found the medical opinion evidence to support a finding of total disability, my crediting of Dr. Baker's opinion would not change the outcome.

Baker's report is also equivocal and, as to the portion that is clear, he has merely recommended no further dust exposure and has not established total disability. Dr. Westerfield also failed to adequately address the issue of total disability, focusing instead on the cause of the impairment, and his reports and depositions are consistent with a finding of either total disability or no total disability. Based upon all of this medical opinion evidence, I find that only the reports of Drs. Simpao and Ducu are sufficiently definite to be entitled to consideration. As noted above, they both found total disability. The only issue therefore is whether they are sufficiently reasoned and documented to satisfy the regulatory criteria.

Although Dr. Ducu's report is short, she does summarize the Claimant's symptomatology as well as cite and attach the clinical findings during her examination, conducted in July 2000. Dr. Broudy has disputed Dr. Ducu's opinion based upon the nonqualifying PFTs upon which she relied,[26] but his report is otherwise equivocal on the issue of whether the Claimant is totally disabled. The mere fact the pulmonary function tests take by Dr. Ducu were nonqualifying is not a basis for discrediting her opinion. *See Cornett v. Benham Coal, Inc.,* 227 F.3d 569 (6th Cir. 2000) (opinion is not properly discredited because it relies upon pulmonary function study yielding numbers over qualifying values). As a treating physician, Dr. Ducu's report is entitled to special consideration pursuant to §718.104(d) based upon the nature, duration, frequency, and extent of treatment. However, as noted above, even though Dr. Ducu treated the Claimant for his pulmonary and other problems over a 15-month period (from February 1999 to July 2000), the limited treatment records available suggest infrequent treatment and do not provide a basis for her opinion being given controlling weight. More importantly, Dr. Ducu's opinion is deficient in that there is no indication that she has considered the physical requirements of Claimant's coal mine employment, which she does not even discuss, in reaching her conclusion that he is 100% totally and permanently disabled.

Dr. Simpao's report is better, in that it lists detailed physical findings and incorporates by reference Claimant's coal mining history form, and he stated that he relied upon "objective findings on the chest X-ray and pulmonary function test along with physical findings and with symptomatology as noted in the report." However, as noted above, Dr. Simpao does not indicate how those findings factored into his opinion. Nevertheless, Dr. Simpao characterized the Claimant's impairment as moderate based upon the findings during his examination and concluded that the moderate impairment prevented the Claimant from performing his previous coal mine employment in a dust free environment. The deficiencies with respect to Dr. Simpao's consideration of Claimant's smoking history do not affect the probative value of his opinion on the total disability issue, as the Claimant's smoking history is irrelevant to that determination. Thus, while Dr. Simpao's opinion suffers from some deficiencies, as discussed above on the issue of pneumoconiosis, I find that it qualifies as a reasoned medical opinion on the issue of total disability.

Although Dr. Simpao relied upon PFTs that were later invalidated by Dr. Burki, Dr. Broudy did not agree that they were invalid, noting that they were not significantly different from those obtained by Dr. Westerfield several days later. Dr. Broudy is as qualified as Dr. Burki to express opinions on that area, as both physicians are board-certified pulmonologists.

[26] Dr. Broudy characterized Dr. Ducu's PFTs as the best in his opinion but he did not explain how he drew that conclusion.

Accordingly, I do not find Dr. Simpao's reliance upon the pulmonary function tests questioned by Dr. Burki to be a basis for discrediting his opinion. *See generally Casey v. Director, OWCP,* 7 B.L.R. 1-863 (1985); *Drenning v. Delta Mining Co.,* 6 B.L.R. 1-60 (1983). *See also Cornett v. Benham Coal, Inc.,* 227 F.3d 569 (6th Cir. 2000) (opinion is not properly discredited because it relies upon pulmonary function study yielding numbers over qualifying values).

I also find that Dr. Simpao has adequately taken into consideration the requirements of Claimant's coal mine employment. Under §718.204(b)(1), the pulmonary and respiratory impairment should be analyzed in relation to the amount of physical exertion required by the job description. Dr. Simpao incorporated by reference Claimant's coal mine employment history form dated August 13, 2001 and also described his most recent job as being an airman and rock duster for Western (sic) Coal Company. Dr. Simpao opined that he lacked the respiratory capacity to perform the work of a coal miner or comparable work in a dust-free environment based upon an impairment that he characterized as "moderate." Dr. Simpao's opinion is to be contrasted with that of Dr. Baker, who merely stated Claimant had a class III impairment and found that he could not work in a dusty environment. Thus, I find that Dr. Simpao sufficiently understood the nature of Claimant's coal mine employment and his degree of impairment and concluded that the lacked the respiratory capacity to perform that work or comparable work in a dust free environment.

Accordingly, based upon the sole reasoned medical opinion addressing the issue of total disability by Dr. Simpao, I find that the medical opinion evidence establishes total disability.

Other evidence. There is additional medical evidence consisting of hospital and medical records and the Claimant's testimony. (DX 33). The pulmonary function tests, arterial blood gases, and report by Dr. Ducu, are discussed above. In addition, the medical examination reports indicate the symptoms reported by Claimant and he also testified about them. Specifically, he complained of shortness of breath, both productive and nonproductive cough, limitation of activities due to exertional dyspnea, and nocturnal dyspnea, requiring that he sleep on three pillows. Overall, the medical records do not add much to the equation, but Claimant's testimony and medical histories substantiate his complaints of exertional dyspnea and his difficulty performing most activities.

Section 718.204(b)(2) as a whole. Looking at §718.204(b)(2) as a whole, I find that the Claimant has established total disability. In this regard, the pulmonary function tests and medical opinions support a finding of total disability, although the arterial blood gases do not. However, the regulations also require that the medical evidence be considered along with the requirements of Claimant's coal mine employment. Here, Claimant testified that his last coal mine employment (with Westerman from 1983 to 1989) was primarily as an air man, which involved airing out the area around the face of the mine. In addition to work as an air man, he told medical practitioners that he did rock dusting and shooting coal. Dr. Simpao incorporated by reference Claimant's list of coal mine employers, noted that his last coal mine employment was as an airman and rock duster, and opined that he lacked the respiratory capacity to perform the work based upon an impairment that he characterized as "moderate." On the form for Description of Coal Mine Work, Claimant characterized his last employment as "General mine labor" and stated that he "did whatever needed to be done" from 1983 to 1989 and was required

to lift between 50 and 75 pounds several times daily. Claimant's employment in the mines therefore involved some heavy work. Based upon the Claimant's description of his work and his current complaints, the pulmonary function test results, and the medical opinion evidence, I find that the Claimant has proven total disability from a pulmonary or respiratory condition by a preponderance of the evidence.

Causation of Total Disability

After establishing that a miner is totally disabled, a claimant must still establish that the miner's total disability was caused at least in part by his or her coal mine employment. 20 C.F.R. §718.204(a). *See Cross Mountain Coal, Inc. v. Ward*, 93 F.3d 211, 216 (6th Cir. 1996). If the presumptions are not available to a claimant, that claimant must prove the etiology of the disability by a preponderance of the evidence, even if he or she has proven the existence of total disability. *See Tucker v. Director,* 10 B.L.R. 1-35, 1-41 (1987). To obtain benefits, a claimant must show that he is totally disabled, not merely by a respiratory or pulmonary condition, but by pneumoconiosis. *See Zimmerman v. Director, OWCP*, 871 F.2d 565, 566 (6th Cir. 1989). Where a physician finds that the miner's disability is due to smoking and pneumoconiosis, the evidence satisfies the "at least in part" test. *See Ward*, 93 F.3d at 218. In *Brumley v. H.C. Coal Co.,* No. 98-3602 (6th Cir. 1999) (unpub. Order), the Sixth Circuit noted:

> . . .This court has held that, when the ALJ has found that the evidence establishes the existence of pneumoconiosis, he should then treat as "less significant" physicians' reports finding no pneumoconiosis, when determining causation of the miner's total disability. *See Skukan v. Consolidation Coal Co.*, 993 F.2d 1228, 1233 (6th Cir. 1993), *vacated on other grounds,* 512 U.S. 1231 (1994); *Adams v. Director, OWP,* 886 F.2d 818, 826 (6th Cir. 1989).

Id. at 5. The Board, however, held to the contrary in *Chaffin v. Peter Cave Coal Company,* 22 B.L.R. 1-294 (2003) and found error in discounting an opinion that Claimant's impairment was due to asthma and not pneumoconiosis by a physician (Dr. Zaldivar) who did not find pneumoconiosis.

Under the amended regulations, a claimant must show that "pneumoconiosis . . . is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment," which means that it had a material adverse effect on the miner's respiratory or pulmonary condition or that it materially worsened a totally disabling respiratory or pulmonary impairment caused by a disease or exposure unrelated to coal mine employment. 20 C.F.R. § 718.204(c)(1). In making this determination, the finder-of-fact must not take into account any non-pulmonary or non-respiratory impairments a miner may have, unless said condition causes a chronic respiratory or pulmonary impairment. 20 C.F.R. §718.204(a).

Thus, the new regulations place an additional burden upon the Claimant to establish a substantial contribution by pneumoconiosis. In this regard, the Department of Labor commented in the preamble to the regulations that "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed.

Reg. 79,946 (Dec. 20, 2000). However, the new regulations also allow for a finding of total disability due to pneumoconiosis even when there is another totally disabling respiratory or pulmonary condition if pneumoconiosis has a material adverse effect or materially worsens an unrelated total respiratory or pulmonary disability. *See* 20 C.F.R. § 718.204 (2001).[27]

The Benefits Review Board had an opportunity to examine this new provision in *Gross v. Dominion Coal Corp.*, 23 B.L.R. 1-10 (2003).[28] In that decision (slip op. at 6 to 7), the Board held that an opinion (by Dr. Forehand) stating that pneumoconiosis was one of two causes of the miner's totally disabling pulmonary condition, but which did not attempt to specify the relative contributions of coal dust exposure and cigarette smoking, was sufficient to satisfy the new standard. The Board found that the doctor's opinion satisfied that "material adverse effect" requirement. The Board also found that substantial evidence supported the administrative law judge's discrediting of the opinion offered by the employer's expert (Dr. Castle) under *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997), which held that an administrative law judge should consider the explanation provided by an expert offering an opinion.

However, in its unpublished decision in *Phillips v. Westmoreland Coal Company,* BRB No. 04-0379 BLA (Benefits Review Board Jan. 17, 2005), the Board indicated that under *Gross*, an opinion which stated that pneumoconiosis was one of two causes of a miner's totally disabling pulmonary condition was sufficient (even if it did not attempt to apportion the relative contributions), but that a report that did not address all of the etiological factors for the miner's total respiratory disability was inadequate (even though it stated unequivocally that the Claimant's disability was caused by pneumoconiosis). *Phillips* slip op. at 3 to 4. The Board went on to note that "[a] physician must state the basis for his opinion and explain how the objective data supports his diagnosis in order for his opinion to be considered both documented and reasoned." *Id.*

I have examined the opinions of each of the physicians addressing this issue:

- Dr. Baker did not find total disability, instead merely recommending that the Claimant be removed from the environment causing his impairment (as discussed above). A fair reading of Dr. Baker's opinion is that such impairment as the Claimant does have due to CWP, hypoxemia, COPD, and bronchitis was due at least in part to coal dust exposure. As noted above, Dr. Baker has discounted smoking as a factor due to a somewhat underestimated smoking history, but he has also taken into consideration the remoteness of that history, which is undisputed. However, his statement does not go so far as to say that pneumoconiosis was a substantially contributing cause of the Claimant's total disability. Dr. Baker's opinion is insufficient to establish disability causation, although it tends to support such a finding.

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[27] As noted above, in *National Mining Assn. v. Dept. of Labor*, 292 F.3d. 849 (D.C. Cir. 2002), the U.S. Court of Appeals for the D.C. Circuit found the portion of 20 C.F.R. § 718.204(a) providing that unrelated nonpulmonary or nonrespiratory conditions causing disability will not be considered in determining whether a miner is totally disabled due to pneumoconiosis to be impermissibly retroactive. The section was otherwise upheld.

[28] The decision is available on the BRB website, which may be accessed via a link from the OALJ website, www.oalj.dol.gov.

- Dr. Simpao opined that the Claimant had a moderate pulmonary impairment caused by coal mine employment and that the impairment prevented the Claimant from performing his coal mine employment. On the initial form, he stated that "Multiple years of coal dust exposure is medically significant in his pulmonary impairment." However, as noted above, he has relied upon an underestimated smoking history of 11 years (as opposed to 18 years) and an incorrect termination date (1975 versus the mid 1980's). The report does not explain what conclusions Dr. Simpao reached as to the impact of Claimant's smoking history. It is not clear whether this report satisfies the standard set forth in the Board's decision in *Phillips*, in that it does not address the other potential etiological factors and does not explain how the factors impacted Claimant's breathing. Nevertheless, Dr. Simpao's opinion tends to support a finding of disability causation.
- Dr. Westerfield opined that the Claimant's respiratory condition was primarily related to asthma with chronic bronchitis and was not caused by coal mine dust. He did not find pneumoconiosis so his opinion is entitled to less significant weight under *Brumley* and *Skukan*, discussed above (although it must be considered under *Chaffin, supra.*). He also did not find total disability nor did he squarely address the issue. His exclusion of coal mine dust as a factor is based in part upon the negative x-rays, including his own inadmissible interpretation of an earlier x-ray (although I have found the x-ray evidence to be positive) and his assumption that CWP in its simple form is not progressive (an assumption that is contrary to the new regulations). His reliance upon those factors entitles his opinion to less weight.
- Dr. Broudy found that the Claimant's pulmonary impairment was due to a number of factors including obesity, chronic obstructive airways disease and "perhaps some predisposition to asthma or bronchospasm," and that deconditioning and cardiac disease could also be playing a role in his symptoms. He attributed the obstructive airways disease to smoking and not coal mine dust exposure; however, that determination was based upon the assumption that obstructive impairment is almost always caused by smoking rather than particular findings relating to Claimant. Here, Claimant's impairment is also restrictive. Like Dr. Westerfield, he did not find pneumoconiosis or total disability so his opinion is entitled to less weight. Moreover, his exclusion of coal mine dust as a factor was based in part on his 1994 examination, which has been excluded from the record.
- Dr. Ducu, Claimant's treating physician, found the Claimant to be totally disabled due to symptoms from "COPD – pneumoconiosis – Black Lung." Dr. Ducu explained that her attempt to treat these conditions with inhalers had been unsuccessful and that there was no major improvement when he was worked up for heart failure. Based upon those factors, she concluded that "the major culprit for his symptoms seems to be COPD-Black Lung." Her opinion satisfies *Gross*, in that she has opined that the COPD and the pneumoconiosis or Black Lung have combined together to result in the disability. While I do not automatically give her opinion additional weight because of her status as treating physician (because of the factors previously discussed), I find her conclusions that the Claimant's condition was due to the combined effects of COPD and Black Lung to have probative value in view of her exclusion of other possible causes during her workup of the Claimant for treatment purposes.

In view of the above, I find that the medical opinion of Dr. Ducu is sufficient to establish that the Claimant's disability was due in significant part to pneumoconiosis under the regulations. The opinion by Dr. Simpao also supports that finding. I further find that the opinion of Dr. Baker is also supportive of a finding that the Claimant's respiratory disability is due in part to coal mine dust exposure, even though he does not state that the causative effect was significant. Drs. Westerfield and Broudy relied upon impermissible factors to exclude any possible contribution by coal mine dust exposure to the Claimant's overall disability, and I therefore find that they do not undermine the opinion of Dr. Ducu. In view of the above, I find that the Claimant has established disability causation.

Conclusion

Having established all of the requisite elements of entitlement under the Act and regulations by a preponderance of the evidence, Claimant is entitled to receive benefits.

Onset Date

Under section 725.503(b), the date for commencement of benefits is "the month of onset of total disability," but "[w]here the evidence does not establish the month of onset, benefits shall be payable to such miner beginning with the month during which the claim was filed." None of the medical evidence or testimony offered in connection with this claim conclusively establishes the precise date that Claimant first became totally disabled due to pneumoconiosis. Accordingly, benefits shall commence as of August 2001, the date Claimant first filed this claim for benefits. (DX 2).

Attorney's Fee

No award of an attorney's or representative's fee is made herein because no fee application has been received. *See* 30 U.S.C. § 932; 33 U.S.C. § 928. The Claimant's attorney shall have thirty days for submission of a fee application in conformance with 20 C.F.R. Part 725 and the other parties shall have thirty days to file any objections, provided that these dates may be extended upon the stipulation of the parties or for good cause shown.

ORDER

IT IS HEREBY ORDERED that the claim of Everett J. Stamper for black lung benefits be, and hereby is, **GRANTED** and Westerman Coal Company, Inc. shall commence payment of benefits and shall reimburse the Trust Fund for interim benefits paid.

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PAMELA LAKES WOOD
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.